STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN00158187: Substantiated: No deficiencies cited. Facility Number: 005075 Date; 11/26/14 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor St. Vincent Hospital and Health Services is in compliance with 410 IAC 15-1.5-6, Nursing Services; and 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules. QA Review: JLee 12-09-14	S 000		